F I S C A L I M P A C T R E P O R T

SPONSOR Deborah Armstrong **ORIGINAL DATE / LAST UPDATED** _____ **HB** 313

SHORT TITLE Surprise Billing Protection Act **SB** _____

ANALYST Martinez

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	NFI	NFI	NFI	NFI	NFI	NFI

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of Superintendent of Insurance
Department of Health
Office of the Attorney General

SUMMARY

Synopsis of Bill

House Bill 313 is intended to provide for the protection of those covered under health insurance from unexpected billing from providers that do not participate in a health benefits plan.

Section 1: Added short title – Surprise Billing Protection Act

Section 2: Added all new definitions. Of importance is the definition of "health benefits plan" which excludes accident only policies, credit-only policies, long term care or disability income policies, specified disease policies, Medicare supplement policies, federal TRICARE policies, fixed indemnity policies, dental-only policies, vision only policies, worker's compensation policies, and automobile medical payment policies, as well as any other policies as defined by the superintendent.

Section 3: Includes the definition of a "surprise bill" which is defined as: an emergency medical, mental or behavioral health service or ambulance service provided to a covered person by a nonparticipating provider. It includes services that are rendered by a nonparticipating provider at a participating facility, or services rendered by a nonparticipating provider when the covered

person was referred by a participating provider to a nonparticipating provider without the covered person's written acknowledgement.

Persons who elect to go to a nonparticipating provider when a participating provider is available are excluded from this bill.

Section 4: Provides instructions to health carriers providing that they should cover services necessary to screen and stabilize a covered person in an emergency, at a hospital, or someone who is in need of emergency services. This section also states that a health care provider may not require prior authorization for emergency services and that the health care provider is liable for payment of fees to a nonparticipating provider of covered emergency services. A health care provider may impose a copayment when nonparticipating services are rendered in an emergency, up to the amount that would have been paid to a participating provider.

Section 5: Providers for non-emergency services coverage. In non-emergency services, a health carrier is liable for coverage in accordance with the health care plan and a covered person will not be liable for fees to a nonparticipating provider other than applicable copayments and deductibles when: the facility is obligated under contract with the health carrier to provide them, when the covered person does not have the ability or opportunity to choose a participating provider, and when medically necessary care is unavailable within a health benefit plan's network.

Section 6: Hold harmless clause. The nonparticipating provider may not submit a surprise bill to the covered person for any amount in excess of what the cost-sharing amounts would have been if the service had been provided by a participating provider. This includes a requirement for similar language in a health benefits plan.

Section 7: A nonparticipating provider may not offer a discount or waive a copayment as a way to induce a person into going to a nonparticipating provider.

Section 8: Includes language requiring hospitals to provide surprise bill complaint forms. By December 31, 2017, the superintendent shall adopt and promulgate rules to specify the format and content of the surprise bill complaint form. A health carrier must also post the form on their website. A hospital must also post the form on their website.

Also includes language requiring that, upon request by the covered person, a health carrier shall provide disclose the allowed amount of admission, procedure or health care service, or the amount that will be charged for the admission, procedure or service. In the event that a health carrier is unable to quote a specific amount the health carrier shall disclose the incomplete nature of the estimate, inform the covered person of the providers ability to update the estimate, disclose what is known concerning the estimated amount or what will be charged.

Section 8 also allows for health carriers to disclose information comparing price for the required health care service at a selected hospital versus other hospitals within the provider's network.

Section 8 also states that the requirements of this section to not apply to unscheduled health care services or health care services scheduled fewer than five days prior.

Section 9: Requires the nonparticipating provider to repay the covered person in the event of

overpayment.

Section 10: Direct dispute resolution. This section does not prevent the participating provider and nonparticipating provider from agreeing on a payment amount for a health care service. In the event that the two do not reach an agreement 45 days after the start of negotiations, each party must submit a formal dispute resolution request to the superintendent including all of the claims.

Section 11: Independent dispute resolution. A health carrier or a nonparticipating provider may initiate binding arbitration to determine reimbursement. Arbitration shall be initiated by filing a request with the superintendent. The superintendent must post a list of resolution organizations and both parties must agree within five days. If they cannot, a list of five providers shall be provided. The party initiating arbitration must first eliminate two, the other party then eliminates two and the remaining will be arbitrator. Prior to requesting arbitration, the party initiating must state its final offer before arbitration occurs. The arbitrator must issue a written decision if a settlement cannot be reached.

Section 12: Provides for confidentiality of records.

Section 13: Provides for enforcement by the superintendent. A superintendent may enter a cease and desist order and may impose a civil penalty of no more than $5,000 for each act in violation of this bill, or may impose a penalty of no more than $10,000 for each willful act of this bill. Fines shall not exceed $300,000.

Section 14: This bill does not create a private cause of action for violations.

Section 15: Grants rulemaking powers to the superintendent as needed to enforce this bill.

Section 16 and 17: creates severability and applicability provisions.

This legislation protects privately insured individuals against surprise billing for health care services obtained out-of-network in emergency circumstances or at in-network health care facilities without the consent of the insured. Should a covered person receive an unexpected, out-of-network health care service, a health care provider may obtain an assignment of benefits under the covered person's health insurance contract to seek out payment of any unpaid charge. The health care provider receives an assignment of benefits by either by option of the covered person or automatically by directly billing the insurance carrier. Upon assignment of the plan's benefits to the health care provider, the consumer is held harmless for any remaining balance bill other than what they owe under their plan contract.

A health carrier may pay the unpaid claim as charged, or may negotiate the payment rate with the provider. If there is a dispute between the provider and the health carrier about the payment rate, the bill provides for an informal dispute resolution process. If the informal dispute resolution process does not succeed, then the bill creates a process for arbitration of the payment dispute.

The arbitration process allows for consideration of the final claim settlement offers of the insurers and the provider, as well as usual and customary charges and payments in the geographic area in which the health care provider rendered the services, experience level of provider, among other factors. Fees for the arbitration process are to be split between the provider and the carrier. The arbitration process is set up to incentivize settlement of claims

payment disputes through informal resolution.

The legislation also creates avenues for educating consumers on avoiding surprise billing situations before they happen. Specifically, the legislation requires hospitals to post their contracted insurance networks on their website. The legislation also requires health carriers to provide consumers information before receiving scheduled services about in-network status of their providers.

FISCAL IMPLICATIONS

The Office of Superintendent of Insurance (OSI) states that the largest volume of complaints received each year by OSI's Managed Care Bureau, the agency's consumer assistance division, is from surprise bills. In recent years, this volume has been growing. This legislation may eventually lessen the number of complaints or turn around the trend in volume increase of complaints related to surprise billing. As a result, the legislation may curb a trend that would ultimately result in OSI needing additional staff to handle surprise billing complaints. As written, the legislation's impact on OSI staffing needs is minimal.

This legislation also may impact uncompensated care rates in New Mexico. By shifting responsibility for payment of surprise medical bills from consumers onto insurers, providers may see more compensation of their services, lessening the need for state and local fiscal support.

SIGNIFICANT ISSUES

The following significant issues were provided by the Office of Superintendent of Insurance, Department of Health, and The Office of the Attorney General:

It appears that the scope of HB313 would extend to payments for air ambulance services. Air ambulances provide both emergency and non-emergency services and most, if not all, air ambulances are out of network. New Mexico has a very limited number of high acuity healthcare/treatment centers and these few resources respond to the entire state. Whereas time is critical in an emergency setting, minimizing transportation time will often exclude road travel and require air ambulance services.

The provisions of HB313 are significant, insofar as states have historically been deemed preempted from regulating the amounts that air carriers (including air ambulances) can charge for services. Air ambulance billing is of concern in general, especially in New Mexico. In January of 2017, the Office of the Superintendent of Insurance issued a report concerning air ambulance billings in New Mexico, which included a discussion of "reverse preemption" in the context of recent litigation in the state of Texas, where the legislature adopted a law that requires insurers to pay the entire amount charged by an air ambulance service. It is unclear whether HB313 was intended to address air ambulance billings in the same way; although it appears that it may have the same effect.

Data on the impact of balance billing on New Mexico residents is limited. However, a recent New England Journal of Medicine study analyzed out-of-network billing for emergency services. Nationally, 22% of emergency department visits at in-network facilities involved out-of-network

physicians.[1] Locally, this number variously widely by geographic region. In Northern New Mexico, the average patient sees an out-of-network bill for a visit at an in-network emergency department between 12% and 16% of the time. For Southern New Mexico, including the Las Cruces area, that percentage rises to more than 54% of visits to in-network emergency departments resulting in out-of-network bills. This legislation would shift the cost burden of these out-of-network medical bills away from individuals to their insurance providers.

Variations of House Bill 313 have been enacted in several states, including California (for Medicaid patients), New York, Illinois, and Connecticut. This bill being new to New Mexico, there is no prior case law.

In 2011, an unpublished opinion granted a motion to dismiss where in-network physicians challenged an Illinois version of this bill, overcoming equal protection, due process, and contract clause claims. The Court summarily rejected the claims made by the in-network physicians as having no right to a due process claim on a right to earn a livelihood, as the legislation did not bar physicians from the right to earn a living by requiring health plan providers to pay out of network providers similarly to in-network providers during an emergency. See, Peoria Tazewell Pathology Grp., S.C. v. Messmore, No. 11-CV-4317, 2011 WL 4498937. (N.D. Ill. Sept. 23, 2011). Thus far, this has been the only significant litigation to arise from similar bills.

JM/jle

[1] New England Journal of Medicine, "Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise" November 2016